

Radius Residential Care Limited - Althorp

Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity: Radius Residential Care Limited

Premises audited: Althorp

Services audited: Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Dementia care

Dates of audit: Start date: 8 August 2016 End date: 9 August 2016

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 107

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
Yellow	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
Red	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Radius Althorp has been owned and operated by Radius Residential Care Limited since October 2015 and cares for up to 117 residents requiring dementia, hospital (medical and geriatric) or specialist hospital (psychogeriatric) level care. On the day of the audit there were 108 residents. The service is managed by a registered nurse with experience in aged care management. She is supported by a Radius regional manager and a clinical manager. Residents and the GP interviewed spoke positively about the service provided.

This certification audit was conducted against the relevant Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures; the review of residents and staff files, observations and interviews with residents, relatives, staff and management.

This audit has identified areas for improvement around wound reviews, aspects of medication management and restraint monitoring.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Policies and procedures adhere with the requirements of the Code of Health and Disability Services Consumers' Rights (the Code). Residents and families are informed regarding the Code and staff receive ongoing training about the Code.

The personal privacy and values of residents are respected. There is an established Māori health plan in place. Individual care plans reference the cultural needs of residents. Discussions with residents and relatives confirmed that residents and where appropriate their families, are involved in care decisions. Regular contact is maintained with families including if a resident is involved in an incident or has a change in their current health. Families and friends are able to visit residents at times that meet their needs.

There is an established system for the management of complaints, which meets guidelines established by the Health and Disability Commissioner.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Services are planned, coordinated and are appropriate to the needs of the residents. A facility manager and clinical manager are responsible for day-to-day operations. Goals are documented for the service with evidence of regular reviews. A quality and risk

management programme is embedded in practice. Corrective actions are implemented and evaluated where opportunities for improvements are identified.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. An education and training plan is being implemented and includes in-service education and competency assessments.

Registered nursing cover is provided 24 hours a day, 7 days a week. The integrated residents' files are appropriate to the service type.

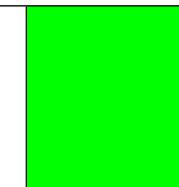
Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Entry to the service is managed primarily by the registered nurses, team leaders and clinical nurse manager. There is comprehensive service information available. Initial assessments are completed by a registered nurse. Care plans and evaluations are completed by the registered nurses within the required timeframes. Care plans are written in a way that enables all staff to clearly follow their instructions. Each resident has access to an individual and group activities programme. The group programme is varied and interesting. Medication is stored appropriately in line with legislation and guidelines. Staff have had education around medication management and all staff who administer medications have completed a competency assessment. General practitioners review residents at least three monthly or more frequently if needed. Meals are prepared on site. The menu

is varied and appropriate. Individual and special dietary needs are catered for. Alternative options are able to be provided. Residents and relatives interviewed were complimentary about the food service.

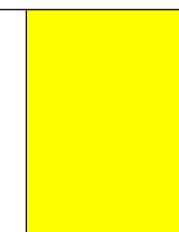
Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building has a current warrant of fitness and emergency evacuation plan. Ongoing maintenance issues are addressed. Chemicals are stored safely throughout the facility. All bedrooms are single occupancy and have their own ensuite. There is sufficient space to allow the movement of residents around the facility using mobility aids. There are a number of small lounge and dining areas throughout the facility in addition to its main communal areas in each wing. The internal areas are able to be ventilated and heated. The outdoor areas are safe and easily accessible and secure for the wings that require this. Cleaning and maintenance staff are providing appropriate services.

There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. There is an approved evacuation scheme and emergency supplies for at least three days.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of low risk.
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Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures for the safe assessment and review of restraint and enabler use. The restraint coordinator maintains a register. During the audit, one resident was using a restraint and four residents were using enablers.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	47	0	1	2	0	0
Criteria	0	98	0	2	1	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Radius Althorp policies and procedures are being implemented that align with the requirements of the Code of Health and Disability Services Consumers' Rights (the Code). Families and residents are provided with information on admission, which includes information about the Code. Staff receive training about resident rights at orientation and as part of the annual in-service programme. Interviews with eight care staff (five who work in the hospital, two who work across all areas and one who works in the psychogeriatric unit), nine registered nurses (five who work in the hospital, including the clinical coordinator and four who work in the psychogeriatric unit, including the clinical coordinator, the diversional therapist and the assistant facility coordinator), confirmed their understanding of the Code. Ten residents (all hospital level of care including one palliative care, two on transitional acute care contracts, one younger person with a disability and one with a long term chronic health condition) and seven relatives (three hospital, one dementia and three psychogeriatric) interviewed confirmed that staff respect privacy, and support residents in making choices.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. The resident or their EPOA signs written consents. Advanced directives are signed for separately. There was evidence of discussion with family when the GP completed a clinically indicated not for resuscitation order. Healthcare assistants and registered nurses interviewed confirmed verbal consent is obtained when delivering care. Discussion with family members identified that the service actively involves them in decisions that affect their relative's lives.</p>

<p>are provided with the information they need to make informed choices and give informed consent.</p>		<p>Eleven of eleven resident files sampled (four from the psychogeriatric, five from the hospital and two from dementia rest home) had a signed admission agreement and consents.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provided opportunities for the family/EPOA to be involved in decisions. The resident files sampled included information on residents' family/whānau and chosen social networks.</p> <p>The Health and Disability Advocacy service has been present at the two most recent family meetings and one resident had been supported by an advocate from this service when making a complaint.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. The activities programme includes opportunities to attend events outside of the facility. Relatives and friends are encouraged to be involved with the service and care.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available at the entrance to the facility, next to the suggestions box. Information about complaints is provided on admission. Interviews with residents and relatives confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints.</p> <p>A complaints register includes complaints received, dates and actions taken. The facility manager signs off each complaint when it is closed. Complaints are being managed in a timely manner, meeting requirements determined by the Health and Disability Commissioner (HDC). There is evidence of lodged complaints being discussed in the quality meetings and staff meetings (where applicable). Twenty-seven complaints have been received in 2016. Two complaints (for the same resident) included the involvement of HDC Advocacy Services, and are closed.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>There is an information pack given to prospective residents and families that includes information about the Code and the nationwide advocacy service. There is the opportunity to discuss aspects of the Code during the admission process. Residents and relatives interviewed confirmed that information had been provided to them around the Code. Large print posters of the Code and advocacy information are displayed throughout the facility. A manager discusses the information pack with residents/relatives on admission. Families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>A tour of the premises confirmed there were areas that support personal privacy for residents. During the audit, staff were observed to be respectful of residents' privacy by knocking on doors prior to entering resident rooms. Staff could describe definitions around abuse and neglect that aligned with policy. Residents and relatives interviewed confirmed that staff treat residents with respect.</p> <p>Resident preferences are identified during the admission and care planning process and this includes family involvement. Interviews with residents confirmed their values and beliefs were considered. Interviews with HCAs described how choice is incorporated into resident cares.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>The Māori health plan policy for the organisation, references local Māori healthcare providers regionally within New Zealand and provides recognition of Māori values and beliefs. Family/whānau involvement is encouraged in assessment and care planning, and visiting is encouraged. Links are established with disability and other community representative groups as requested by the resident/family. Cultural needs are addressed in the care plan.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture,</p>	<p>FA</p>	<p>An initial care planning meeting is carried out where the resident and/or whānau as appropriate, are invited to be involved. Individual beliefs or values are discussed and incorporated into the care plan. Six monthly multi-disciplinary team meetings occur to assess if needs are being met. Family are invited to attend. Discussions with relatives confirmed that residents' values and beliefs are considered. Residents interviewed confirmed that</p>

<p>Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>staff take into account their values and beliefs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Staff job descriptions include responsibilities. The monthly staff (team) meetings include discussions around professional boundaries and concerns as they arise. Management provided guidelines and examples of mentoring for specific situations. Interviews with the managers and care staff confirmed their awareness of professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>Policies and procedures are aligned with current accepted best practice. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff.</p> <p>An annual in-service training programme is implemented as per the training plan with training for registered nurses from the DHB. Radius has provided a Radius roving clinical manager to support the clinical manager and registered nurses since June 2016 and a roving facility manager since May 2016 to support the manager. Outcomes for the service are monitored with benchmarking across all Radius facilities. Feedback is provided to staff via the various meetings and through graphs and notices on the noticeboard in the staff room.</p> <p>There is a minimum of one registered nurse on each shift in the hospital and in the psychogeriatric area, and HCAs are described by residents and family as caring. The service has worked to actively introduce Radius systems and procedures since Radius purchased the facility nine months prior to the audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective</p>	FA	<p>There is an accident/incident reporting policy to guide staff in their responsibility around open disclosure. Staff are required to record family notification when entering an incident into the system. All 20 adverse events reviewed met this requirement when notification was appropriate. Family members interviewed confirmed they are notified following a change of health status of their family member.</p> <p>There have been frequent family/resident meetings in 2016 and regular resident meetings where issues can be addressed.</p>

communication.		There is an interpreter policy in place and contact details of interpreters were available.
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Radius Althorp is a Radius aged care facility located in Tauranga. The facility is certified to provide hospital (medical and geriatric); dementia and psychogeriatric care for up to 117 residents. It was purchased by Radius in October 2015. Radius has decided to no longer accept dementia level residents. Existing dementia level residents (seven) have been placed in one of the psychogeriatric wings. This mixed co-location has been approved by Mental Health Services for Older People (MHSOP), the rationale being that mixing functional capabilities can improve outcomes for the appropriate individuals (evidenced in an email from BOP Portfolio Manager, dated 8 August 2016).</p> <p>Residents living at the facility during the audit totalled 107. Fifty-two residents were at hospital level of care, seven at dementia level of care and forty-eight at psychogeriatric level of care. There were two residents (hospital level) under the young persons with disability contract; one resident (hospital level) under the chronic health long-term support contract; two residents (hospital level) under the DHB funded palliative care contract, one resident (hospital level) under the DHB funded respite contract and two residents (hospital level) under the DHB funded transitional acute care contract. Nine beds (hospital level) are dedicated to the DHB contract. The DHB funded respite bed for dementia level of care was unoccupied.</p> <p>The business plan describes the vision, values and objectives of Radius Althorp. Goals are linked to the business plan. Goals are reviewed a minimum of three-monthly and the business plan is updated annually.</p> <p>The facility manager is a registered nurse with eight years of aged care experience and four years in operational and facility management roles. She has been in the role since February 2016 and is supported by a regional manager.</p> <p>The facility manager has maintained at least eight hours of professional development activities related to managing an aged care facility.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely,</p>	FA	<p>The clinical manager/RN covers during the temporary absence of the facility manager. For extended absences, Radius has interim (roving) facility managers who cover facility manager absences. The regional manager is available on consultative basis.</p>

appropriate, and safe services to consumers.		
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>An established quality and risk management system is embedded into practice. Quality and risk performance is reported across facility meetings and to the regional manager. Discussions with the managers (regional manager, facility manager and clinical manager/RN), and staff reflected staff involvement in quality and risk management processes.</p> <p>Resident and family meetings are at least two-monthly. Minutes are maintained. Annual resident and relative surveys are planned for October 2016.</p> <p>The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The clinical managers group with input from facility staff reviews the service's policies at a national level every two years. Clinical guidelines are in place to assist care staff. Updates to policies included procedures around the implementation of InterRAI and health and safety to the new Act.</p> <p>The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. There are clear guidelines and templates for reporting. The facility has implemented established processes to collect, analyse and evaluate data, which is utilised for service improvements to a standard that exceeds the requirements. Results are communicated to staff in meetings and on staff noticeboards. Corrective action plans are implemented when opportunities for improvements are identified (eg, internal audit results are lower than 95%). Corrective actions are signed off when completed.</p> <p>Health and safety policies are implemented and monitored by the health and safety committee. Two health and safety representatives (facility manager and maintenance staff) and the regional manager were interviewed about the health and safety programme. One maintenance staff member has completed external health and safety training. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Radius has achieved tertiary level ACC WSMP.</p> <p>Falls prevention strategies are in place with a recent quality initiative called the "Watch Lounge Trial" whereby two HCAs are designated watcher's in the psychogeriatric units. Falls have decreased over the past two months although they remain above the Radius benchmark. Prevention strategies are implemented when a resident has two or more falls. Strategies include sensor mats, perimeter mattresses and impact mats. Residents at risk of falling are also placed on a toileting plan.</p>

<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>There is an incident/accident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise and debriefing. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow-up action required. They are signed off by the clinical manager when complete.</p> <p>A review of twenty accident/incident forms identified that forms are fully completed and include follow-up by a registered nurse. Accident/incident forms are completed when a pressure injury is identified. Neurological observations are done two hourly for any suspected injury to the head. The clinical manager is involved in the adverse event process.</p> <p>The facility manager and regional manager were able to identify situations that would be reported to statutory authorities including (but not limited to) infectious diseases, serious accidents and unexpected death. Toi Te Ora Public Health were notified during a gastro outbreak (24 December 2015). A section 31 report was sighted for one grade-three pressure injury.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Human resources policies include recruitment, selection, orientation and staff training and development. There has been a 50% turnover rate since Radius purchased the facility in October 2015. Seventy-three staff have been recruited since the purchase with only seven of the new staff resigning (96% retention rate). Families interviewed commented on the high turnover of staff.</p> <p>Thirteen staff files reviewed (four RNs, eight HCAs, one cleaner) included a recruitment process (interview process, reference checking, police check), signed employment contracts, job descriptions and completed orientation programmes. A register of registered nursing staff and other health practitioner practising certificates is maintained.</p> <p>The orientation programme provides new staff with relevant information for safe work practice. There is an implemented annual education and training plan that exceeds eight hours annually. There is an attendance register for each training session and an individual staff member record of training. Staff are required to complete written core competencies during their induction. These competencies are scheduled to be repeated annually. Fifty HCAs are employed to work in the psychogeriatric wings with thirty-eight having completed their dementia qualification. Twelve HCAs are in the process of completing their qualification and have been employed for less than one year.</p> <p>Registered nurses are supported to maintain their professional competency. Six registered nurses have completed their InterRAI training, one is in training and seven are on the waiting list. There are implemented competencies for registered nurses including (but not limited to) medication competencies and insulin competencies.</p> <p>Performance appraisals are scheduled for September – November 2016.</p>

<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>A policy is in place for determining staffing levels and skills mix for safe service delivery. Rosters implement the staffing rationale. There is a minimum of one RN and one EN covering the four PG wings (all in very close proximity) and two RN covering the hospital wings. They are supported by a clinical coordinator and a clinical manager. Activities are provided five days a week.</p> <p>Staff were observed attending to call bells in a timely manner. Staff interviewed stated that overall the staffing levels are satisfactory and that the managers provide good support.</p> <p>Residents interviewed reported there are sufficient staff numbers although family have expressed some concerns.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The residents' files were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access. Entries are legible, dated and signed by the relevant HCA or nurse including designation. Residents' files demonstrate service integration. A locked room stores archived residents' files.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>The service has comprehensive admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The clinical nurse manager screens all potential residents prior to entry and records all admission enquires. The admission agreement form in use aligns with the requirements of the ARC and ARHSS contract. Exclusions from the service are included in the admission agreement. The information provided at entry includes examples of how services can be accessed that are not included in the agreement.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p>	FA	<p>There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. Relatives interviewed confirmed they were kept well informed about all matters pertaining to residents, especially if there is a change in the resident's</p>

Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.		condition.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate	The medication management policies and procedures comply with medication legislation and guidelines. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Medication administration practice complied with the medication management policy for the medication rounds sighted. Medication prescribed is not always signed as administered on the pharmacy generated signing chart. Registered nurses administer medicines. All staff that administer medication are competent and have received medication management training. The facility uses a robotics pack medication management system for the packaging of all tablets. The RN on duty reconciles the delivery and documents this. The 22 medication charts sampled, were written correctly by medical practitioners and there was evidence of three monthly reviews by the GP. One resident self-administered medicines and was competent to do so.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	There is a fully functional kitchen and a contracted company cooks all food on site. There is a food services manual in place to guide staff. A resident nutritional profile is developed for each resident on admission and provided to the kitchen staff. This document is reviewed at least six monthly as part of the care plan review. The kitchen is able to meet the needs of residents who require special diets and the kitchen manager works closely with the RNs on duty. The kitchen staff have completed food safety training. The kitchen manager and cooks follow a rotating seasonal menu, which has been reviewed by a dietitian. The temperatures of refrigerators, freezers and cooked foods are monitored and recorded. There is special equipment available for residents if required. All food is stored appropriately. Residents and the family members interviewed were very happy with the quality and variety of food served. All units have a variety of food available over the 24-hour period and staff reported the kitchen manager is very responsive to special requests.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the	FA	The service records the reason for declining service entry to potential residents should this occur and communicates this decision to potential residents/family/whānau. Anyone declined entry is referred back to the referring agency for appropriate placement and advice.

consumer and/or their family/whānau is managed by the organisation, where appropriate.		
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	All appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. InterRAI assessments were completed and were reviewed at least six monthly or when there was a change to a resident's health condition in files sampled. Care plans reviewed have been developed on the basis of these assessments.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The long-term care plans reviewed described the support required to meet the resident's goals and needs and identified allied health involvement under a comprehensive range of template headings. Residents and their family/whānau are involved in the care planning and review process. Short-term care plans reviewed were in use for changes in health status. Staff interviewed reported they found the plans easy to follow.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Moderate	<p>Registered nurses (RNs), team leaders, clinical manager and healthcare assistants follow the care plan and report progress against the care plan each shift. If external nursing or allied health advice is required the RNs will initiate a referral (eg, to the district nurse). If external medical advice is required, this will be actioned by the GP. Staff have access to sufficient medical supplies (eg, dressings). Sufficient continence products are available and resident files include a continence assessment and plan. Specialist continence advice is available as needed and this could be described.</p> <p>Wound assessment and wound management plans were in place for 25 residents with 48 wounds including 12 pressure areas (two acquired prior to admission).</p> <p>Not all wounds had been reviewed within the stated timeframes. The RNs have access to specialist nursing wound care management advice through the district nursing service.</p> <p>Care plan interventions including intentional rounding and food and fluid charts demonstrate interventions to meet residents' needs. All two hourly turning charts consistently document two hourly turns.</p>

<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>A diversional therapist leads the activities team, which includes a further four activities coordinators. All members of the activities team work 30 hours per week and provide programmes in different units from Monday to Friday. One activities coordinator covers two of the 15 bed dementia/psychogeriatric units and another, the other two psychogeriatric units. Activities in the two units that share an activities coordinator are often combined. One activities coordinator provides activities in the McLeod hospital wings and another in the Reuben hospital wing. Each resident has an individual activities assessment on admission and from this information an individual activities plan is developed as part of the care plan by the registered nurses, with input from the activities staff. Each resident is free to choose whether they wish to participate in the group activities programme or their individual plan. Participation is monitored. Group activities reflect ordinary patterns of life and include planned visits to the community. All long-term resident files sampled have a recent activities plan within the care plan and this is evaluated at least six monthly when the care plan is evaluated. Dementia and psychogeriatric unit files sampled included appropriate activities to manage behaviour over the 24-hour period. Each wing has a 24-hour activity box that HCAs use to engage residents in activities when the activities staff are not present. The HCA orientation process includes time with the diversional therapist who provides information around engaging residents in activities.</p> <p>Residents interviewed commented positively on the activity programme.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The registered nurses evaluate all initial care plans within three weeks of admission. The long-term care plan is evaluated at least six monthly or earlier if there is a change in health status. There is at least a three monthly review by the GP. All changes in health status are documented and followed up. Care plan reviews are signed by an RN. Short-term care plans are evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files sampled. Where progress is different from expected, the service responds by initiating changes to the care plan.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service</p>	<p>FA</p>	<p>The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The nurses initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family as evidenced in interviews and medical notes. The staff provided examples of where a resident's condition had changed and the resident was reassessed.</p>

providers is appropriately facilitated, or provided to meet consumer choice/needs.		
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles are available and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals sighted were labelled correctly and stored safely throughout the facility. Safety datasheets are available.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building has a current building warrant of fitness.</p> <p>The facility is in two sections – one hospital and one containing the dementia/psychogeriatric units. The hospital service is provided from three wings over two floors and the psychogeriatric/dementia service is provided from four 15-bed wings in very close proximity (link 1.2.1 about the mixed co-location of dementia and psychogeriatric level residents in one 15-bed wing).</p> <p>The building has a number of alcoves and lounge areas in each wing. There is a full-time and a part-time maintenance person employed to address the reactive and planned maintenance programme. All medical and electrical equipment was recently serviced and/or calibrated and hoists and electric beds serviced. Hot water temperatures are monitored and managed within 43-45 degrees Celsius. The facility has sufficient space for residents to mobilise using mobility aids. The external area is well maintained. Each psychogeriatric/dementia unit has a separate secure garden area and a walking path around the unit perimeter. Residents have access to safely designed external areas that have shade. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p>	FA	<p>All rooms in the facility have a full ensuite large enough to cater for hospital level residents and the associated equipment and staff. Additionally there are communal toilets near each lounge and separate toilets for staff and visitors. Communal toilets have privacy systems in place. Residents interviewed confirmed their privacy is</p>

Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.		assured when staff are undertaking personal cares.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	All residents rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids, including those required by hospital level care residents. Residents are encouraged to personalise their bedrooms.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	The communal areas include the open plan main lounge/dining area (with a kitchenette in the hospital wings) and several smaller lounges in each wing. The communal areas are easily and safely accessible for residents.
Standard 1.4.6: Cleaning And Laundry Services	FA	The facility is cleaned by dedicated cleaning staff. They have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. Residents interviewed were satisfied with the standard of cleanliness in the facility.

<p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>		<p>All laundry is carried out in the on-site commercial laundry by dedicated laundry staff that cover 15 hours per day. Residents and relatives interviewed were satisfied with the laundry service.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>There are emergency and disaster manuals to guide staff in managing emergencies and disasters. There is a minimum of one first aid trained staff member on every shift and during outings. The facility has an approved fire evacuation plan. Fire drills take place every six months (last July 2016). Smoke alarms, sprinkler system and exit signs are in place. A generator is available in the event of a power failure. Emergency lighting is in place, which is regularly tested. A civil defence kit is in place. Supplies of stored water (in tanks on the site) and food are held on site and are adequate for three days. Electronic call bells are evident in resident's rooms, lounge areas, and toilets/bathrooms.</p> <p>The facility is kept locked from dusk to dawn. The village on the same site has regular drive-bys by a security company and evening and night staff complete security checks.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>General living areas and all resident rooms are appropriately heated and ventilated. All rooms have external windows that open, allowing plenty of natural sunlight.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers,</p>	<p>FA</p>	<p>Radius Althorp has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system and the Radius KPIs. A registered nurse (the psychogeriatric unit clinical coordinator) is the designated infection control nurse with support from the facility manager, clinical manager, the quality management committee and the infection control team. Minutes are available for staff of quality meetings and infection control meetings (three monthly). Audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The Radius infection control programme</p>

service providers, and visitors. This shall be appropriate to the size and scope of the service.		was last reviewed in July 2016.
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	A registered nurse at Althorp is the designated infection control (IC) nurse. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team (comprising of representatives from different departments) has good external support from the local laboratory infection control team and IC nurse specialist at the DHB. The infection control team is representative of the facility. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	There are Radius infection control policies and procedures appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies were developed by the Radius clinical management team and have been reviewed and updated.
Standard 3.4: Education	FA	The infection control policy states that the facility is committed to the ongoing education of staff and residents.

<p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>		<p>Formal infection control education for staff has occurred. The infection control nurse has completed recent on-line infection control training. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Infection surveillance is an integral part of the infection control programme and is described in Radius' infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow-up, review and resolution. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually, and provided to Radius head office. Infections are part of the key performance indicators. Outcomes and actions are discussed at quality meetings and infection control meetings, and placed on the staffroom noticeboard. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the acting facility manager. A norovirus outbreak in December 2015 appeared well managed.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The clinical manager is the designated restraint coordinator. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures are comprehensive, and include definitions, processes and use of restraints and enablers.</p> <p>There were four (hospital level) residents using enablers and one (psychogeriatric level) resident using restraint during the audit.</p> <p>A resident file of a resident using an enabler (bedrails) was reviewed. The resident gave written consent for the use of bedrails. The enabler was linked to the resident's care plan and was regularly reviewed.</p> <p>Staff training is in place around restraint minimisation and enablers, falls prevention and analysis and management of challenging behaviours.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining</p>	<p>FA</p>	<p>The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (clinical manager) and for staff are documented and understood. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements.</p>

<p>approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>		
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>A restraint assessment tool is completed for residents requiring an approved restraint for safety. Assessments are undertaken by the restraint coordinator, in partnership with the RNs, GP, resident and their family/whānau. Restraint assessments are based on information in the care plan, resident/family discussions and observations.</p> <p>Ongoing consultation with the resident and family/whānau are evident. The file for the (psychogeriatric level) resident using restraint was reviewed. The completed assessment considered those listed in 2.2.2.1 (a) - (h).</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>PA Low</p>	<p>Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint.</p> <p>Restraint authorisation is in consultation/partnership with the resident, family and the GP. The use of restraint is linked to the resident's restraint care plan. An internal restraint audit, conducted six-monthly, monitors staff compliance in following restraint procedures.</p> <p>Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Consistent evidence to verify two hourly checks was missing on the monitoring forms for the resident using restraint.</p> <p>A restraint register is in place providing an auditable record of restraint use and is completed for residents requiring restraints and enablers.</p>
<p>Standard 2.2.4: Evaluation</p>	<p>FA</p>	<p>The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations are conducted three-monthly and include family, evidenced in one resident file where restraint was in use. The restraint coordinator reported that restraint use is also discussed monthly in the restraint meeting. This was confirmed in the meeting</p>

Services evaluate all episodes of restraint.		minutes.
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>The Radius restraint minimisation programme is discussed and reviewed at a national level and includes identifying trends in restraint use, reviewing restraint minimisation policies and procedures and reviewing the staff education and training programme.</p>

Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA Moderate</p>	<p>Medication administration practice complied with the medication management policy for the medication rounds sighted. Medication prescribed is signed as administered on the pharmacy generated signing chart but not all prescribed medication had been signed as administered.</p>	<p>Four of 22 medication charts sampled did not have all prescribed medication recorded as administered.</p>	<p>Ensure that all prescribed medications administered are recorded in the medication signing chart.</p> <p>30 days</p>

<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Low</p>	<p>Interviews with registered nurses, the clinical manager and team leaders demonstrated an understanding of the assessment, monitoring and wound management plans. All wounds had an appropriate assessment and plan but not all had been reviewed when required.</p>	<p>Eight of 48 wounds documented had not been reviewed within the stated timeframes.</p>	<p>Ensure that all wounds are reviewed within the stated timeframes.</p> <p>30 days</p>
<p>Criterion 2.2.3.4</p> <p>Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:</p> <p>(a) Details of the reasons for initiating the restraint, including the desired outcome;</p> <p>(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;</p> <p>(c) Details of any advocacy/support offered, provided or facilitated;</p> <p>(d) The outcome of the restraint;</p> <p>(e) Any injury to any person as a result of the use of restraint;</p> <p>(f) Observations and monitoring of the consumer during the restraint;</p> <p>(g) Comments resulting from the evaluation of the restraint.</p>	<p>PA Low</p>	<p>Each episode of restraint use is scheduled to be monitored at a frequency determined by the restraint assessment. Evidence of two hourly monitoring for one resident using a chair brief as a restraint was not being documented in a consistent manner.</p>	<p>Consistent evidence to verify two-hourly monitoring for one resident using a chair brief as a restraint was missing.</p>	<p>Ensure monitoring forms are completed accurately and reflect staff checking residents during restraint use at a frequency determined by each resident's restraint assessment.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.